Tennessee Department of Children's Services

RELEASE FROM MEDICAL RESPONSIBILITY

Date: _____ Time: _____AM/PM
(day/month/year)

This is to certify that I _____

Number _____, a patient at _____

am refusing the following treatment: _____

_____

_____

_____

I refuse this treatment against the advice of the attending physician and his/her assistants. I acknowledge that I have been informed of the risks involved and hereby release the State of Tennessee, Department of Children's Services, and their employees from all responsibility for any ill effects which may result from my refusal. I may withdraw this refusal at any time without fear of reprisal.

Youth's Signature	Number	Date

Witness' Signature	Date

Witness' Signature	Date

Original: Health Record
Copy: File

CS-0093